

Coping with obligations towards patient and society: an empirical study of attitudes and practice among Norwegian physicians

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Abstract

A questionnaire relating to attitudes towards setting economic priorities within the health care system was sent to all 151 general practitioners in Northern Norway. Of these, 109 (72 per cent) responded. Ninety-six per cent of the respondents agreed or partly agreed that the setting of economic priorities within the health care system was necessary. Ninety-three per cent had experienced a conflict between their responsibility towards the individual patient and the requirement for them to manage the health budget.

The responses suggest that doctors act more in the interests of their patient than the interests of society. However, 68 per cent reported having refrained from giving the best treatment to patients because it was too expensive. As many as 60 per cent of the respondents wanted more public guidelines. Only 10 per cent wanted doctors to have more influence in difficult questions arising from setting priorities.

Introduction

In any consultation, the physician is traditionally expected to offer her/his patient the best possible examination and treatment. This is stated explicitly in the declaration of Geneva: 'The health of my patient will be my first consideration' (1). On the other hand, whilst the demand for health services is expanding, the resources are limited. Consequently, all treatments cannot be offered to all patients with the result that during a consultation, patient and society, to some extent, have opposing interests. In principle, society will benefit from restricted spending, allowing more to be used for other purposes. In contrast, the patient will benefit from unrestricted use of resources in her/his best interest. If the doctor is obliged to promote both the interests of the patient and of society, she/he must cope with the conflicting interests arising. In other words, doctors may perform a double role as the patient's advocate and a manager of society's health funds.

Key words

Medical ethics; setting priorities; questionnaires; general practitioners; dual role.

The main topics we wanted to investigate were:

1. Is this dual set of obligations recognized, and considered to present a problem?
2. How do doctors balance the obligations towards both patient and society?

Method

The questionnaire was formulated with the aim of clarifying these points through the clinical choices and opinions of the doctors involved in the survey. The questionnaire was sent to all 151 general practitioners in the northernmost counties in Norway in March 1993. One reminder was sent out. By the deadline, two months later, 109 (72 per cent) questionnaires had been returned. Seventy per cent of the respondents were men and 70 per cent were below 40 years of age. Only one per cent was over 60. This represents approximately the distribution of age and sex in the population surveyed.

Only simple frequency analysis has been carried out. The questions have been translated from Norwegian.

Results

The results are given in percentages. The questions are shown along with the results.

Question 1

Your patient Olav Jensen has been suffering from tension headaches during the last month. He has a stressful job as a nursery nurse, and suggests that a week off work 'would help'. You doubt that there is adequate justification for a medical certificate. Which of the following alternatives best describes what you would do?

Responses

Sixty-eight per cent: I would prescribe a sick note. The interest of my patient is my primary responsibility and when there is some doubt, I give priority to the wishes of my patient

Twenty-nine per cent: I would not prescribe a sick

note. The payments are made from a joint fund and when there is some doubt, I emphasize that others could make better use of the resources
Three per cent: No response given

Question 2

Mrs Andersen is your patient. She is 60 years old and has developed a common, serious and chronic illness. There are two good alternatives for medical treatment with an identical clinical effect: 'A' and 'B'. The only difference between the two except for the price, is that 'A' is administered three times daily whilst 'B' is administered once a day. The expenses of both 'A' and 'B' are covered by the national health system. Mrs Andersen is mentally lucid.

Treatment 'A' costs NOK 2000 (approximately £200) per year of treatment. How much would 'B' have to cost for you to prescribe 'A' for economic reasons, for Mrs Andersen?

Responses

Fifteen per cent: 2,100 NOK/year
Thirty-seven per cent: 3,000 NOK/year
Forty-one per cent: 5,000 NOK/year
Five per cent: 10,000 NOK/year
Zero per cent: 30,000 NOK/year
Two per cent: Other amount
Zero per cent: No response given

On average the doctors considered the difference between one and three administrations daily to be worth NOK 2000 per year (equivalent to about £200).

Question 3

You are the first to arrive at a serious car accident. The first casualty you come across is unconscious. She has a crushed jaw and to secure open airways, you must pull her jaw. You can see that there are other people unconscious inside the car 10 metres away. Presuming that no others arrive, which of the following alternatives best describes what you would do?

Responses

Seventeen per cent: My primary responsibility is to the first woman I came across. I would not leave her to see if any of the others are in immediate need of my help
Eighty per cent: I have an equal responsibility for all the casualties. This means I shall have to leave the first woman to see if any of the others are in immediate need of my help
Four per cent: No response given

Question 4

Do you agree or disagree that there is an expanding gap between what is medically possible and what can be economically achieved under the Norwegian health care system, and that this gap makes economic priorities necessary?

Responses

Seventy-seven per cent: Agree
Nineteen per cent: Partly agree
Three per cent: Partly disagree
One per cent: Disagree
Zero per cent: No response given

Question 5

What is your opinion of public guidelines for doctors' decisions relating to individual patients, for example, who should be offered expensive acute medical treatment, bone-marrow transplants, or rehabilitation after cerebrovascular accidents?

Responses

Sixty per cent: There should be more public guidelines
Ten per cent: The decisions should be made by the doctors to a greater extent than is the case at present
Twenty-six per cent: The present arrangement is satisfactory
Five per cent: No response given

Question 6

Have you ever refrained from giving the best treatment to your patient because it would cost society too much?

Responses

Zero per cent: Very often
Six per cent: Often
Sixty-two per cent: Sometimes
Twenty-seven per cent: Never
Five per cent: No response given

Question 7

In daily consultations with your patients, do you feel like an administrator of society's health funds?

Responses

Sixty-eight per cent: Usually
Twenty-nine per cent: Not usually
Three per cent: No response given

Question 8

Have you received sufficient information about the costs of your daily decisions to feel competent as a manager of common health funds?

Responses

Thirty-nine per cent: Mainly yes
Fifty-one per cent: Mainly no
Eight per cent: I do not feel like a manager of health funds
Two per cent: No response given

Question 9

Have you ever felt any conflict between your responsibility to your patient and your responsibility for managing society's health resources?

Responses

Four per cent: Very often
Thirty-seven per cent: Often
Fifty-two per cent: Sometimes
Six per cent: Never
One per cent: No response given

Discussion

The response rate was generally high, indicating basic acceptance of the problems set. We also invited the respondents to make comments. The general comment was that the questions were difficult, but relevant. There was a demand for more information on the cases given. Question 1 received most negative criticism because its options included inappropriate details.

The group of general practitioners surveyed have some noteworthy characteristics. In Norway, and especially in the north of Norway, the population is extremely scattered. The geographical isolation has given general practitioners there a tradition of being remarkably independent. They have been responsible for the health services of an entire community. The health services in Norway are still almost exclusively financed by public funds. However, the total spending on health services in the last decade only amounts to approximately seven per cent of Gross National Product (GNP). An important part of fund allocation by the doctors occurs in their daily consultations with patients (2,3). The independent role and the daily handling of public services have perhaps made the doctors surveyed more familiar with the idea of balancing the interests of patient and society.

The low median age of the population surveyed is due to the fact that primary care in the North of Norway tends to be the starting point of physicians' careers. It is difficult to estimate how this has influenced the response profile.

Is the dual set of obligations recognized and considered a problem?

Most of the doctors surveyed (96 per cent), agreed or partly agreed that the gap between what is required and what is possible within the health system is widening, making the setting of economic priorities unavoidable (question 4). Almost all the respondents (93 per cent) have often or sometimes experienced a conflict between the dual responsibilities towards patients and society (question 9). A high 68 per cent responded that on one or more occasions, they had avoided giving their patient the best treatment because they considered it too expensive for society (question 6). Thus, there is widespread agreement that all patients cannot always have the best medical treatment available.

Two-thirds of the respondents usually feel like administrators of society's health funds during

consultations (question 7). At the same time, only 39 per cent felt competent to govern health resources (question 8). Even though it would represent a reduction in their influence, the majority of the doctors wanted to be relieved of the responsibility of setting difficult priorities. In question 5, 60 per cent asked for further public guidelines in difficult questions to do with setting priorities, whereas only 10 per cent wanted doctors to have more influence in such matters.

Thus, it seems that the respondents both recognized the dual obligation and regarded it as a burden.

How do doctors balance their obligations towards their patients and society?

Questions 1 and 2 outline a balancing of the interests of one single patient with the interests of society as a whole. When the consequences of the doctors' individual decisions are transferred to society's health budget, they can assume unexpectedly high significance. If Mrs Andersen (question 2) suffered from rheumatoid arthritis, with a prevalence of one per cent (4), and if all patients were offered the same convenient treatment form, the additional annual cost for Norway (4 million inhabitants) would be about NOK 80 million (equivalent to about £8 million). It is reasonable to assume that most of the respondents would not have given priority to the difference in administration so readily if they were responsible for the whole budget. In question 1, 68 per cent would prescribe a sick note when requested by their patient, even if they were in doubt about the justifications for it. We interpret these answers as a sign that doctors feel greater loyalty towards their patients than to the rest of society.

The balancing of the interests of the individual and the interests of the group is completely different in question three. On arriving at a car accident, 80 per cent of the doctors would leave the patient they first encountered, even though it meant that she might die, to see whether the other casualties needed immediate help. In other words, they were willing to sacrifice the first patient for the benefit of the others.

There are many important differences between questions one and two compared with number three. Most strikingly, the car accident concerns a much more serious condition than the other two questions. However, it might be of interest to look at E Haavi Morreim's distinction between commodity scarcity and fiscal scarcity, to explain the difference in attitude. 'In commodity scarcity some discrete item is in limited supply, ... we can also be fairly sure that if one patient is denied the resource, some other needy person will nevertheless benefit' (5). She points out that fiscal scarcity is profoundly different from this: '... the consequences of fiscal allocations are anything but clear. Obviously, the decision to order a \$2,000 course of antibiotics rather than a \$2

course means that \$1,998 will not be available for some other patient or use. But beyond that, consequences are amorphous' (5).

In Morreim's terms, the car accident is an example of commodity scarcity, where the doctor is the commodity. In question three, what was not given to one was obviously given to others. Mrs Andersen's case, and the problem with the sick note, is an example of fiscal scarcity. It is difficult to define exactly who would benefit if Mrs Andersen was given a cheaper prescription or if Olav Jensen didn't get the sick note he asked for. The society as a whole is anonymous and massive. Money in huge budgets governs the inhabitants' needs, but it seems unethical, or even impossible, to decide on a person's needs based on figures in a budget. The physician is thus systematically trapped in an inescapable conflict.

Conclusion

In a survey among senior doctors in North Norway, we found widespread acceptance of the need for setting priorities within the health care system. The respondents experienced a conflict of loyalty between managing society's health resources and promoting the interests of their patients. There seemed to be a tendency towards giving the individual patient a higher priority, when less was known about the alternative use of the resources.

There was a demand for more public guidelines on the difficult problems of setting priorities.

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Trude Arnesen and Stole Fredriksen were medical students at the University of Tromsø, Norway when they wrote this paper. They graduated in Spring. Trude Arnesen is now studying for a Master of Public Health degree at Autonoma University in Madrid and Stole Fredriksen is working as a general practitioner in Bodø, Norway.

References

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News and notes

An Appraisal of the Thought of H Tristram Engelhardt

A conference entitled *Ethics, Medicine and Health Care: an Appraisal of the Thought of H Tristram Engelhardt* will be held at Youngstown State University, Youngstown, Ohio on September 29th and 30th this year.

The conference is in recognition of the publication of the second edition of Engelhardt's *The Foundations of Bioethics*, and is sponsored by the Ethics Center of Youngstown State University and the Center for Ethics of St Elizabeth Hospital Medical Center.

The conference will include plenary and break-out

sessions. The plenarists are James Nelson (The Hastings Center), E Haavi Morreim (College of Medicine, University of Tennessee), Stanley Hauerwas (Duke University), Kevin Wildes, SJ (Kennedy Institute of Ethics, Georgetown University), and H Tristram Engelhardt. For further information contact: Brendan Minogue, PhD, Director, Ethics Center, Youngstown State University, Youngstown, OH 44555-1465. Telefax: 216-742-2304.